Loudoun Sports Therapy Center
The Leader in Physical Therapy

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____
Address: _____City:_____ State:_____ Zip:_____
☐I am requesting the records to be released to myself.
Recipient's Name:_____ Relationship:_____
Recipient's Address:_____City:_____State:_____Zip:_____

Please check each of the following Protected Health Information (PHI) that you would like released:

- ☐ Therapy Evaluation
- ☐ All treatment Notes
- ☐ Physician Orders
- ☐ Itemized Bill

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if it is requested.
6. I may obtain a copy of this form after it is signed.
7. The person/entity listed below may obtain a copy of these records, but may not disclose them to anyone else without a separate written consent, unless allowed by federal law.

Please note that Virginia statutes allow a fee schedule as follows: $10.00 retrieval fee and $.50 per page copied up to 50 pages. In the event this is an out of state request, the statute allows a $15.00 retrieval fee, $.50 per page up to 50 pages, and an additional 10% shipping and handling fee.

I have read the above and authorize the disclosure of the medical records as stated.

Signature:_____ Date:_____
Expiration Date:_____

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